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ABSTRACT

Few questions in psychotherapy are of greater importance than the relationship among practitioners, researchers, and managed care. The present and future roles of psychotherapy are covered here. Despite ample evidence that psychotherapy does work, its effectiveness continues to be questioned. When psychotherapy research emerged some 50 years ago, researchers sought to understand patient-therapist dynamics, the nature of treatment outcomes, and the isolation of the effective ingredients in the therapeutic encounter. However, in the 1970s, people demanded greater accountability of practitioners and many persons exhibited hostility toward psychotherapy. People wanted to know if psychotherapy worked; this was a fair question in the beginning, but the question is still currently being raised. People now want empirically validated treatments, thus creating an unholy alliance between managed care companies and hard-nosed researchers in which treatment manuals are given precedence over clinical skills. This focus ignores the fact that psychotherapy is anchored in a human relationship and that it is closer to education than to treatment. Subsequently, assigning a limited number of hours for patient treatment will not work. Greater understanding and tolerance for the conflicting interest of different parties are required. Contains 14 references. (RJM)

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Research, Practice, and Managed Care

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Abstract

Despite ample evidence that psychotherapy is an effective treatment, this well-documented conclusion continues to be assailed. Similarly, the demand for treatment manuals has been met and treatment manuals have been shown to be of value, although their value is limited. In the same vein, time-limited forms of therapy can produce change but such changes will in most cases be modest. There is also reason to believe that well-trained experienced practitioners are superior service providers. There needs to be greater tolerance and greater realism in accepting what psychotherapy can and cannot do. Most important, it must be accepted that it cannot perform miracles.

Research, Practice, and Managed Care

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Few if any questions in psychotherapy are of greater importance today and in the foreseeable future than the relationship between practitioners, researchers, and managed care. "Managed care" systems, as Howard & Mahoney (1996) correctly point out, are really "managed cost" systems, their basic purpose being cost-containment, that is, to conserve as much as possible the health-care dollar, in short, to provide a rationale for the equitable distribution of public funds. As citizens and tax payers we clearly must recognize the need for some system that accomplishes this objective with a minimum of hardship to consumers, professionals, and the public purse. Given limited financial resources, the truth is that it probably cannot be done. What is already emerging and will become more sharply delineated in the coming years is a reemergence of the old two-tier system of medical care, that is, differential treatment of "private patients" and "clinic patients," a disjunction between private care and indigent care, between "first-class" and "economy class."

A good deal has been written about the allegedly conflicting interests of psychotherapy research and practice, the limited impact of research on clinical practice, and the manner in which the practicing therapist might make greater use of research findings (e.g., Talley, Strupp & Butler, 1994). To be sure, in many ways research in psychotherapy and the practice of psychotherapy are different enterprises; however, few would dispute that practice should be informed by research, as research should be

informed by practice. There is no simple, straightforward translation of research findings into the consulting room and no such translation should be expected. In my view, research exerts a more indirect, and perhaps more subtle effect on the practitioner. I will presently pursue this subject but for the moment wish to note that there need be no intrinsic animosity between professionals and researchers, and that both groups--I take pride in having been a member of both camps over the years--have much to profit from each other, as do patients and society. There needs to be greater collaboration between the two, and this is a cardinal point I wish to stress. On the other hand, I take strong exception to the manner in which research has been used, if not to say co-opted, as a tool for undergirding the rationing of therapeutic services. Let me elaborate.

When psychotherapy research came into being some fifty years ago, the driving force, as in any scientific discipline, was the search for a better understanding of the patient-therapist dynamics, the nature of treatment outcomes, and the isolation of the effective ingredients in the therapeutic encounter. As a voluminous literature attests, there is no question that significant progress has been made (Strupp & Howard, 1992). I think it is also fair to say that research results have had a palpable effect on modifications in clinical practice.

However, already in the 1970s voices were heard in public forums (e.g., in the U. S. Senate) that demanded greater accountability of practitioners, and a fair amount of hostility toward the practice of psychotherapy had previously been shown in the early days of psychoanalysis. In the 1950s skeptics (e.g., Eysenck, 1952) turned to the outcomes of empirical research to question the utility and value of psychotherapy.

Practitioners for their part--I am referring here primarily to organized psychoanalysis--assumed an arrogant attitude that dismissed systematic research as superfluous (as Freud had done) if not a manifestation of the investigators' psychopathology. While the declining fortunes of psychoanalysis are only in part attributable to this stance, it certainly contributed heavily to the analysts' failure to engage in empirical research or at least to collaborate with researchers.

The primary question that has been raised about psychotherapy by an ever-growing chorus of critics, legislators, and public policy-makers has related to its effectiveness: Does psychotherapy work? At the beginning, this was certainly a reasonable question and no one can take issue with the desire of the public to be informed about this subject. As the voluminous literature of psychotherapy convincingly attests (cf. Smith, Glass & Miller, 1980; Lambert & Bergin, 1994), this question has been adequately answered in detail and depth. What is troubling to the community of practicing therapists as well as researchers, is that the question continues to be raised again and again, which leads to the strong suspicion that the questioners are driven by motives other than the quest for empirical demonstrations. What we are dealing with, it seems to me, are political and ideological considerations that are largely impervious to empirical data: In this field, many people unfortunately continue to believe what they want to believe, and they don't want to be "confused" by facts.

The latest version of this problem is the demand for "empirically validated" treatments (Task Force, 1995), an objective that has produced what in my judgment is an unholy alliance between managed care companies and hard-nosed researchers who

seem to subscribe to the goal that at some future date it may be possible to practice psychotherapy by slavishly following a treatment manual and that clinical skills may be largely expendable. Having participated in the creation of a treatment manual (Strupp & Binder, 1984) and having engaged in extensive research aimed at assessing the potential and the limitations of the manual (Strupp, 1993; Henry et al., 1993a; 1993b) I have emerged from these experiences with the strong conviction that manuals can be of value but that they will always remain of limited value (Strupp & Anderson, 1996). In addition to the findings of my research group and accumulating research evidence, particularly research addressed to the therapeutic alliance (Horvath & Greenberg, 1994), I base this conclusion on the following considerations which impress me as incontrovertible:

1. Irrespective of its theoretical underpinnings, psychotherapy is anchored in, and fundamentally inseparable from, a human relationship. Thus it makes no difference whether or not relationship variables are specifically conceptualized as critical to the process and outcome of therapy, they are forever part and parcel of the therapeutic enterprise.

2. Accordingly, psychotherapy is a treatment only in a metaphorical sense and, as Freud already recognized, it is much closer to education--to learning and unlearning--than to medical treatment, specifically to drug treatment.

The dilemma faced by researchers, practitioners, as well as insurance carriers is the foregoing incompatibility. There is no need to rehearse well-known facts, such as: Consumers of psychotherapy suffer from conditions that are characterized as "psychiatric disorders", which call for medical "diagnosis," that psychotherapy is a form

of healing, therefore akin to medical treatment, that many conditions for which psychotherapy is prescribed are the outcome of both biological and developmental defects, that the only acceptable model (in our society) for treating these conditions is the medical model, and that for these reasons the outcomes of psychotherapy are per force measured in terms of symptomatic changes. To be sure, there are measures, rating scales, etc. that go beyond symptom reduction and are focused on a person's life functioning and well-being but in this era of managed care the latter are accorded scant attention. And for good reasons: symptom changes are incomparably easier to achieve and measure than are emotional well-being, contentment, inner peace, self-esteem, and the like. Yet, psychotherapy at its best can point to such achievements but we also know that in most instances they cannot be brought about in 4, 6, 15, or even 30 hours of therapy. Most well-trained and experienced therapists are accustomed to think more realistically in terms of months and, not uncommonly, years.

In this era of cost-containment, managed care, "down-sizing" and the emergence of ever briefer forms of psychotherapy, it is almost sacrilegious to advocate a sober examination of what our field may be sacrificing in this process. (Let me note in passing that I would not pen these phrases if I were a young therapist about to embark on a career; however, as a senior citizen I can indulge in this luxury.) It is one thing, it seems to me, to recognize that in the face of a shrinking health care economy we must accept more or less severe restrictions imposed on our professional activities[1]. It is quite another matter to create the impression (to the field, the public, and the managed care companies) that brief or time-limited forms of psychotherapy are fully comparable,

perhaps even superior, to more intensive or extended forms. Our profession, including notably researchers, have contributed materially to what I consider a misinterpretation or inadequate recognition of clinical realities. To be sure, patients frequently recover relatively rapidly from, say, a single depressive episode but this says little about relapse or recurrence. I am not suggesting that longer term or more intensive therapy can regularly point to stupendous achievements but it is simply a clinical fact that (a) many patients suffer from long-standing disorders (including personality disorders) that do not readily yield to short-term psychotherapy and (b) numerous patients, while not incapacitated, say in the work area but significantly impaired in their interpersonal relations and enjoyment of life can be substantially helped by more extensive forms of psychotherapy where reconstruction of the personality is the aim. Part of the problem lies with the character of the outcome assessments that are insufficiently comprehensive and/or insufficiently sensitive to more subtle aspects of human functioning.

A related problem is the quality of psychotherapists. Just as the quality and extent of therapy has become blurred by socio-political and economic issues, so has the quality of practitioners and the extent of their training which has become diluted and trivialized. Research studies are frequently cited in support of the contention that clinical training and skills are inconsequential and perhaps largely expendable (Dawes, 1994). Based on our research at Vanderbilt University involving the intensive study of psychotherapists before, during, and following training in time-limited dynamic psychotherapy, we have adduced evidence that (a) therapeutic skills are NOT easily acquired and perfected; (b) there are marked individual differences in competence, even

among therapists who have undergone specialized training; and (c) many differences between therapists judged competent and less competent are subtle. I find myself in agreement with the Supreme Court justice who said he can't define pornography but he can recognize it when he sees it. There is some difficulty in sharply delineating clinical skills but we can recognize them when we see them. More easily identified are deficiencies and shortcomings in a therapist's performance. I must leave a detailed account of therapeutic skills for another occasion.

I wish to conclude by pointing to another unsolved problem facing practitioners, researchers as well as insurance carriers. I am referring to the need for clearly identifying the extent to which therapeutic services should be provided. The present-day approach appears to be largely symptom-oriented. In the case of depression, for example, the goal seems to be geared to treating the current episode without significant regard for recurrence or relapse. By the same token, the prevailing philosophy is to provide the minimum amount of care which is typically accomplished by curtailing the number of treatment hours as sharply as possible.

The fact that in the case of depression there are frequent recurrences seems to be largely left out of account. Is this approach the most cost-effective one in the long run? Might more extensive or intensive therapy prevent or possibly curtail future occurrences? If, following this reasoning, greater weight were given to prevention, who should pay for this effort--the patient or the managed care company? What is the evidence that efforts at prevention in the form of more extensive therapy are more (or less) cost-effective in the long run, not to mention possible increments in the patient's

well-being, his or her effectiveness as a marital partner, breadwinner, etc.? Preventive efforts on a broader front might mitigate juvenile delinquency, divorce, and other adverse consequences that might in the long run be more costly than psychotherapy.

In sum, psychotherapy clearly has much to contribute. The field also needs greater understanding and tolerance for the conflicting interests of the various parties involved in the enterprise.

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Endnote

1. Recent "Treatment Guidelines for Major Depression" promulgated by the Tennessee Department of Mental Health and Mental Retardation provide 8-16 sessions of time-limited dynamic therapy or 12-16 sessions of cognitive-behavioral therapy. They note that co-morbid personality disorders may require longer CBT (i.e., 20-40 sessions).